U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 16 October 2003

CASE NO.: 2002-BLA -5180

In the Matter of:

IVAN RANDALL BLAKE
Claimant

v.

ELM GROVE COAL CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Thomas Johnson, Esq.
For the Claimant

Kathy Snyder, Esq.
For the Employer

Before: DANIEL L. LELAND
Aministrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A formal hearing was held in Wheeling, West Virginia on June 4, 2003, at which all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-35[1], Claimant's exhibits (CX) 1-8[2], and Employer's Exhibits (EX) 1-4, 5 (Dr. Wiot's interpretation of the November 13, 2001 chest x-ray only), 12, 15-16, 19-20 were admitted into evidence. The record was left open for Claimant to submit a rebuttal interpretation of the November 13, 2001 chest x-ray and for Employer to depose Dr. Fino. Claimant submitted Dr. Ahmed's interpretation of the November 13, 2001 chest x-ray on July 23, 2003, which is now admitted as CX 9. Employer submitted the transcript of Dr. Fino's deposition on July 14, 2003, which is now admitted as EX 21. Claimant and Employer submitted closing briefs.[3, 4]

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[1] At the hearing, I admitted the Director's exhibits subject to rulings on the limitations of evidence. Director's exhibit 19 contains Dr. Robert Altmeyer's medical report dated November 7, 1993 and Dr. Harold Spitz's interpretation of the September 26, 2001 x-ray. Further, the medical reports of Drs. Fino and Renn, at Director's exhibits 17 and 19, respectively, contain x-ray interpretations by those physicians. Employer submitted the pulmonary function study and arterial blood gas test contained in Dr. Altmeyer's report as part of its affirmative case pursuant to § 725.414(a)(3)(i). However, Employer did not offer Dr. Altmeyer's medical report or Drs. Fino, Renn, or Spitz's x-ray interpretations as part of its affirmative case or as rebuttal evidence. As this evidence exceeds the evidentiary limitations of § 725.414, Dr. Altmeyer's medical report (except for the pulmonary function study and arterial blood gas test) and Drs. Fino, Renn, and Spitz's x-ray interpretations are excluded from the record.

[2] At the hearing and in its brief, Employer argues that Claimant's exhibit 2 should be excluded because it is not proper rehabilitative evidence. (TR 35-36); *see also Employer's Closing Argument*, pp. 17-18. At the hearing, I reserved ruling on this issue until I could review the evidence. (TR 36-37). Section 725.414(a)(2)(ii) states that:

> where the responsible operator or fund has submitted rebuttal evidence under paragraph (a)(3)(ii) or (a)(3)(iii) of this section with respect to medical testing submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who originally interpreted the chest x-ray or administered the objective testing. Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.

Dr. Cohen's letter is not addressing an x-ray interpretation or medical test that he performed, nor is it explaining his conclusion in light of the rebuttal evidence. I find that Claimant's exhibit 2 is not rehabilitative evidence and therefore it is excluded from the record.

[3] In an Order issued August 15, 2003, I set September 8, 2003 as the due date for closing briefs. Claimant mailed his brief on September 10, 2003. In the cover letter, Claimant's counsel

ISSUES

I. Existence of pneumoconiosis.

II. Causal relationship of pneumoconiosis and coal mine employment.

III. Existence of total disability.

IV. Causation of total disability.

V. Material change in conditions.

FINDINGS OF FACT AND CONCLUSIONS OF LAW[5]

Procedural History

Ivan Randall Blake (Claimant or the miner) filed his first claim for benefits on August 5, 1986. (DX 1-1). The district director denied his claim on January 26, 1987, finding that Claimant had not established any of the elements of entitlement. (DX 1-16). Claimant filed the instant claim for benefits on April 4, 2001. (DX 2). The district director initially determined that Claimant was entitled to benefits on March 6, 2002. (DX 30). Employer requested a formal hearing, and the case was forwarded to the Office of Administrative Law Judges on May 17, 2002. (DX 32, 34).

Background

Claimant was born on September 20, 1926, and has one dependent, his wife, Velma. (TR 61; DX 2). Employer stipulated that Claimant had nineteen years of coal mine employment. (TR 61). Claimant testified that he worked in the coal mines for thirty-one years. (TR 61-64). Claimant's last job was as a general mine foreman. (TR 67). Claimant testified that his duties as general mine foreman included "pleas[ing] the owners of the mines, min[ing] coal, and hav[ing]

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explained that his brief was two days late because of several computer problems during the prior week. I accept Claimant's brief as timely.

On October 3, 2003, Claimant filed a Motion for Leave to Submit Claimant's Response to Part III, "Evidentiary Issues" Section of Employer's Post Hearing Brief. Claimant's Motion is denied.

[4] Claimant and Employer's briefs raise additional evidentiary issues that were presented and ruled upon at the hearing. As the parties do not present any new arguments in their briefs, my previous rulings as to these issues shall stand.

[5] The following abbreviations have been used in this decision and order: TR = transcript of hearing, BCR = board-certified radiologist, B = B-reader.

a good safety record." (TR 66-67). He testified that a lot of miners were laid off in 1983, and so he supervised about one dozen miners mining coal, cleaning up returns and intakes, and installing sump pumps, and he sometimes assisted the miners with these tasks. (TR 68-69, 73). Claimant also walked about three miles a day in order to check the intakes and returns and he walked in a "duck walk" position, which is a stooped down position, a few times per week. (TR 71-72). Claimant testified that when he walked through the mines he carried about thirty pounds of equipment. (TR 73). Claimant retired from coal mine employment in September of 1985. (TR 64, 73).

Claimant smoked about one-half a pack of cigarettes from 1944 or 1945 until 1989. (TR 76). Claimant uses oxygen twenty-four hours a day, which was prescribed by Dr. Lenkey in January of 1998. (TR 77). He also uses a nebulizer about four times per day and an inhaler when necessary. (TR 77). Claimant testified that he can walk about one block with oxygen before getting short of breath. However, he cannot walk up a hill or lift anything. (TR 78). Claimant has never been diagnosed or treated for hay fever or asthma. (TR 79).

Medical Evidence

Chest X-rays

Exhibit	Date	Physician	Interpretation
DX 1-10, 1-12	9/18/86	Kennard, BCR, B	0/1, q/p
DX 1-11	9/18/86	Cole, BCR, B	0/1, q/s
DX 12	6/20/01	Noble, BCR, B	1/0, s/p
DX 13	6/20/01	Gaziano, B	only read quality of x-ray – classified as quality 1
DX 19	6/20/01	Wiot, BCR, B	0/0
CX 7	6/20/01	Ahmed, BCR, B	1/1, t/s
DX 18	9/26/01	Wiot, BCR, B	0/0
CX 8	9/26/01	Ahmed, BCR, B	1/1, t/s
CX 9	11/13/01	Ahmed, BCR, B	1/1, t/s
EX 5	11/13/01	Wiot, BCR, B	0/0
CX 3	10/28/02	Ahmed, BCR, B	1/1, t/s
CX 4	10/28/02	Miller, BCR, B	1/1, t/q
EX 16	10/28/02	Wiot, BCR, B	0/0

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV1	FVC	MVV
DX 1-9	9/18/86	69"	59	2.89	4.39	102
DX 16	9/25/92	68"	66	2.56	4.87	98
DX 19	9/28/93	66.5"	67	2.13	3.93	70.17
				2.25*	4.80*	--*[6]

[6] The post-bronchodilator MVV value for the September 28, 1993 study is unreadable.

Exhibit	Date	Height	Age	FEV1	FVC	MVV
DX 9	6/20/01	70"	74	1.67	3.22	59
DX 17	9/27/01	67.5"	75	1.87	3.86	67
				1.77*	3.84*	68*
DX 19	11/27/01	68"	75	1.62	3.56	57
				1.75*	4.08*	66*

* results post-bronchodilator

Blood Gas Studies

Exhibit	Date	PCO2	PO2
DX 1-8	9/18/86	37.5	78.6
		37.1*	89.0*
DX 19	9/28/93	41.3	66.6
DX 11	6/20/01	36.1	58.6
DX 17	9/27/01	36	59

* exercise values

Medical Reports

Claimant was examined by Dr. Thomas V. Burke on September 18, 1986. (DX 1-7). Dr. Burke noted that Claimant smoked one pack of cigarettes per day for forty-eight years. Claimant's symptoms were cough and dyspnea on exertion. Claimant did not report any walking, climbing, lifting, or carrying limitations. The physical examination was normal. The exercise test was negative for cardiac disease and the arterial blood gas test was normal. Dr. Burke found that there was no evidence of cardiopulmonary disease.

Claimant was examined by Dr. Venu Reddy, a board-certified pulmonologist, on July 10, 2001. (DX 10, 20, p. 5). Dr. Reddy noted that Claimant smoked one-half a pack of cigarettes per day for forty-four years. Claimant's chief complaints were: progressive dyspnea on exertion for twenty years and rare wheezing and coughing. Dr. Reddy noted on examination that Claimant looked dyspneic and that he had decreased breathing sounds bilaterally. Dr. Reddy reviewed a chest x-ray, pulmonary function study, arterial blood gas test, and an electrocardiogram. Dr. Reddy diagnosed chronic obstructive pulmonary disease based on Claimant's history of coal dust exposure, physical examination, and the pulmonary function study results. He also diagnosed coal workers' pneumoconiosis based on Claimant's history of coal dust exposure and positive chest x-ray. Dr. Reddy opined that Claimant's chronic obstructive pulmonary disease is due to cigarette smoking and coal dust exposure. Dr. Reddy found that Claimant has a total pulmonary impairment, and that five percent of Claimant's impairment is due to pneumoconiosis.

Dr. Gregory J. Fino, a board-certified pulmonologist, examined Claimant on September 26, 2001 and reviewed his medical records, and his findings are found in a report dated October 7, 2001. (DX 17). Dr. Fino noted that Claimant smoked less than one pack of cigarettes per day

for forty-four years. Claimant complained of progressive shortness of breath for thirty years, dyspnea when walking up hills, lifting, carrying, performing manual labor, and walking briskly on level ground. Claimant also complained of chest pain and a daily productive cough. Upon examination, Dr. Fino noted decreased breath sounds bilaterally. Dr. Fino performed a pulmonary function study, which revealed a moderate obstruction with no bronchodilator response. Also, the electrocardiogram was normal, the diffusing capacity was reduced, and the arterial blood gas revealed moderate hypoxia. Dr. Fino diagnosed chronic bronchitis and emphysema secondary to cigarette smoking. Dr. Fino opined that Claimant does not suffer from coal workers' pneumoconiosis because a majority of the chest x-rays are negative for pneumoconiosis, the spirometry evidence revealed a progressive obstruction after Claimant left the mines, which is consistent with cigarette smoking, and the reduced diffusing capacity values and hypoxia are consistent with cigarette smoking. Dr. Fino stated that Claimant suffers from a disabling respiratory impairment, but found that it is due solely to cigarette smoking.

Dr. Joseph J. Renn, III, who is board-certified in pulmonary diseases, examined Claimant on November 13 and 27, 2001 and reviewed his medical records, and his findings are summarized in a report dated December 7, 2001. (DX 19). Dr. Renn noted that Claimant worked in the coal mines for thirty-one years and that he smoked one-half a pack of cigarettes per day for forty-five years. Claimant complained of exertional dyspnea since the early 1970s, occasional coughing since 1999, a productive cough since 1999, and occasional wheezing since 1999. The physical examination was normal. The pulmonary function study revealed a moderately severe obstructive ventilatory defect which improved following inhaled bronchodilator. Dr. Renn diagnosed pulmonary emphysema and intrinsic asthma due to cigarette smoking. He found that Claimant does not suffer from pneumoconiosis and that his coal dust exposure did not cause or contribute to his pulmonary emphysema and intrinsic asthma. Dr. Renn found that Claimant did not suffer from a totally disabling respiratory impairment, and thus he was able to perform his last coal mine job.

Dr. Reddy was deposed on January 18, 2002. (DX 20). He testified that Claimant's productive cough was not daily, and so he ruled out chronic bronchitis, but not chronic obstructive pulmonary disease. *Id.* at 12. Dr. Reddy testified that Claimant had a significant smoking history, and noted that tobacco use can cause radiographic evidence of emphysema. *Id.* at 15. Dr. Reddy relied on Dr. Noble's interpretation of the June 20, 2001 chest x-ray, which revealed evidence of pneumoconiosis (1/0, s/p) and emphysema. *Id.* at 18-19. Dr. Reddy stated that it is uncommon for either cigarette smoke or coal dust exposure to create "s" opacities upon x-ray. *Id.* at 18. However, he stated that while the x-ray is not characteristic of coal workers' pneumoconiosis, "certainly it will still go along with the simple coal workers' pneumoconiosis radiographic criteria." *Id.* at 19. Dr. Reddy attributed the radiographic evidence of emphysema to both cigarette smoke and coal dust exposure. *Id.* He testified that coal dust exposure causes central lobular emphysema, but that the specific type of emphysema can only be determined by pathological evidence. *Id.* at 19-20. Dr. Reddy attributed Claimant's chronic obstructive pulmonary disease to both tobacco smoke and coal dust exposure, but he could not determine whether the chronic obstructive pulmonary disease was due solely to cigarette smoking or coal dust exposure. *Id.* at 21-23, 27. Dr. Reddy opined that Claimant has a totally disabling pulmonary impairment. *Id.* at 25. However, he concluded that only five percent of Claimant's impairment is due to coal dust exposure because the radiographic evidence of pneumoconiosis is

minimal. *Id.* at 26. Dr. Reddy attributed the other ninety-five percent of Claimant's impairment to his obstructive airways disease, which is due to coal dust exposure and cigarette smoking. *Id.* at 26-27.

Dr. Robert Cohen, a board-certified pulmonologist, reviewed the medical evidence and his conclusions are found in a report dated February 8, 2002. (CX 1).[7] Dr. Cohen found that Claimant has coal workers' pneumoconiosis and that his chronic respiratory condition is substantially related to his significant histories of coal dust exposure and cigarette smoking. Dr. Cohen found that Claimant's symptoms of severe and progressively worsening shortness of breath and productive chronic cough and the physical findings of decreased breath sounds, rhonchi, and prolonged expiration are consistent with chronic lung disease. Dr. Cohen also based his diagnosis on Claimant's pulmonary function testing, which revealed a progressively severe obstructive defect with diffusion impairment that did not significantly respond to bronchodilators, and the arterial blood gas tests, which showed intermitted hypoxemia. Dr. Cohen criticized Dr. Fino's statement that coal dust would only result in a 200 cc reduction in Claimant's pulmonary function because "it assumes that the average decrement seen in epidemiological studies would apply to an individual patient." *Id.* at 12. Further, he criticized Dr. Renn's opinion that Claimant has asthma because there is no objective data to support that conclusion. Specifically, Dr. Cohen stated that the FVC is not a reliable indicator of bronchodilator response, that the FEV1 is the most important indication in pulmonary functioning, which never improved to normal in Claimant's case, and that a response to bronchodilators does not rule out coal workers' pneumoconiosis. Dr. Cohen opined that Claimant suffers from a totally disabling pulmonary impairment because he has an FEV1 that is 52% of predicted with a diffusing impairment of 24% of predicted. He stated that Claimant's cardiac disease does not affect his finding of an obstructive lung disease with diffusion impairment.

Dr. Attila A. Lenkey, Jr., a board-certified pulmonologist, prepared a medical report dated February 28, 2002. (DX 21). Dr. Lenkey has been Claimant's treating physician since early 1998. Dr. Lenkey noted that he has seen Claimant every three to four months, except for a period in 2000 when he was in another state. Dr. Lenkey reviewed Claimant's medical records and opined that Claimant has emphysema and chronic bronchitis. Dr. Lenkey found that Claimant suffers from a moderately severe pulmonary impairment which is obstructive in nature. He determined that Claimant suffers from a moderately severe pulmonary impairment based on the very reduced FEV1/FVC ratios and the reduced FEV1 values. He also stated that the DLCO testing revealed a very substantial reduction in the diffusing capacity. Dr. Lenkey stated that Claimant does not suffer from asthma because there is little reversibility on the spirometries after the bronchodilators were administered and Claimant did not suffer from significant wheezing. Dr. Lenkey opined that Claimant's chronic obstructive pulmonary disease with reduced diffusing

[7] The record contains two medical reports by Dr. Cohen – one dated February 8, 2002 (DX 21) and one dated August 19, 2002. (CX 1). It appears that the August 19, 2002 report is identical to the February 8, 2002 report, except that a few typographical errors are corrected. At the hearing, Claimant designated the August 19, 2002 report as one of its two affirmative medical reports under § 725.414(a)(2)(i), and therefore all references to Dr. Cohen's report shall be made to CX 1.

capacity is caused by Claimant's cigarette smoking and his coal dust exposure. He also found that Claimant is totally disabled due to his chronic obstructive pulmonary disease with reduced diffusing capacity.

Dr. Renn was deposed on May 30, 2002. (EX 1). Dr. Renn testified that the lung volume study revealed hyperinflation and air trapping, which is consistent with the radiographic findings of emphysema. *Id.* at 28-29. He stated that Claimant's FEV1 had an insignificant improvement post-bronchodilator and that the FVC had a significant response, and thus the spirometry revealed a bronchoreversible airway obstruction. *Id.* at 30. He testified that bronchoreversibility is inconsistent with a coal dust induced lung disease. *Id.* at 32. Dr. Renn opined that Claimant has a moderately severe ventilatory defect that is the combined result of emphysema and intrinsic asthma. *Id.* at 34. He determined that Claimant's emphysema is due solely to cigarette smoking because it is radiographically appreciable, and focal emphysema, which is caused by coal dust exposure, is not. *Id.* at 59-60. Dr. Renn diagnosed Claimant with asthma based on his post-bronchodilator FVC reversibility and a history of wheezing. *Id.* at 63. He also stated that Claimant developed asthma after he left the mines and that asthma cannot be aggravated by coal dust exposure because coal dust exposure causes a different type of inflammatory response than asthma. *Id.* at 65. Dr. Renn stated that Claimant's use of beta blocker drugs to control his heart disease may also be contributing to his obstructive airways disease, as the purpose of those drugs is to decrease the heart rate and thus decrease his ability to exercise. *Id.* at 15, 34. Dr. Renn opined that coal dust exposure did not cause or contribute to Claimant's obstructive airways disease because he had a disproportionate reduction of the volumes and flows by spirometry, which is consistent with a tobacco smoking induced obstructive airways disease. *Id.* at 34-35. Moreover, he stated that Claimant's pattern of impairment is inconsistent with legal pneumoconiosis because legal pneumoconiosis does not cause a reduction in the indirect measures of the small airways, there is no bronchoreversibility with legal pneumoconiosis, lung volume are not affected by legal pneumoconiosis, and there would be a restrictive impairment. *Id.* at 77-78. Dr. Renn concluded that Claimant retains the respiratory capacity to perform his last job because his post-bronchodilator FEV1 was sixty-two percent of predicted, indicating that his impairment is mild. *Id.* at 35.

Dr. Lenkey was deposed on July 15, 2002. (EX 2). Dr. Lenkey testified that he diagnosed chronic obstructive pulmonary disease, which he also refers to as emphysema, based on Claimant's symptoms of dyspnea and shortness of breath on exertion, decreased breath sounds upon examination, and the results of chest x-rays and spirometries. *Id.* at 13, 23. He also testified that Claimant has coal workers' pneumoconiosis based on the positive chest x-ray evidence. *Id.* at 66. Dr. Lenkey stated that Claimant's twenty-three pack year history of smoking is not significant enough to produce a cigarette smoking induced lung disease, but that Claimant's thirty year history of coal dust exposure is sufficient enough to produce a coal dust induced lung disease. *Id.* at 26, 29-30. Dr. Lenkey stated the Claimant has a primarily obstructive impairment. *Id.* at 13. He determined that Claimant did not have a restrictive impairment because a majority of the pulmonary function studies demonstrated that Claimant had a normal FVC. *Id.* at 18. Dr. Lenkey testified in general that a post-bronchodilator FVC improvement is not informative because the improvement could be due to poor patient technique or a poorly supervised study. *Id.* at 32. Instead, he looks at the FEV1 and FEF 25-75 values to determine whether there is a bronchodilator response indicative of asthma. *Id.* at 33. He

testified that the September 28, 1993 and November 27, 2001 pulmonary function studies did reveal significant post-bronchodilator improvement, but he noted that the FVC results went from normal to normal, and that the FVC alone should not be used to make a diagnosis of asthma. *Id.* at 76-77, 79. Dr. Lenkey concluded that Claimant's impairment is equally due to coal dust exposure and cigarette smoking and that the two had an "additive effect." *Id.* at 38-40.

Dr. Cohen was deposed on August 2, 2002. (EX 4). Dr. Cohen diagnosed coal workers' pneumoconiosis based on Claimant's history of coal dust exposure, the physical examinations, the results of the objective testing, and the medical reports. *Id.* at 62. However, he did not find clinical pneumoconiosis because the chest x-ray evidence was "mixed." *Id.* at 31. Dr. Cohen noted that Claimant had significant tobacco smoking and coal dust exposure histories, and stated that:

> from my rather careful review of the literature, from what I can determine, the effect of tobacco smoke on lung function and the effect of coal mine dust on lung function are very very similar and cannot be distinguished by medical testing of any kind…. The effect seems to be exactly additive.… With tobacco smoke and with coal, the effects of toxicity are additive, and that's been very very well demonstrated in many many studies. So if someone has substantial tobacco smoke and substantial coal mine dust [exposure], I can only assume based on my careful review of the literature that those two exposure are additive and have contributed to that impairment.

Id. at 16-17. Dr. Cohen explained that Claimant had three times the normal loss of FEV1 between 1986 and 2001 and that this rate of progression is typical of miners who are sensitive to the toxicity of coal dust and tobacco smoke. *Id.* at 51. He also explained that in 1986, shortly after Claimant left coal mine employment, he had a one-third decline in his FEV1, as compared to his FVC results, which indicates that he already had a obstructive impairment. *Id.* at 53. Dr. Cohen testified that the FEV1 value is the most important measure of an individual's impairment. *Id.* at 57. Dr. Cohen explained that asthma is diagnosed when the FEV1 and FVC values normalize after the administration of bronchodilators. *Id.* at 104. Here, Claimant's FEV1 values did not normalize post-bronchodilator and his FVC values were normal before the administration of bronchodilators, and so he would not diagnose Claimant with asthma. *Id.* Further, Dr. Cohen discussed the medical literature at length, and concluded that it shows that coal dust exposure produces a loss in the FEV1 and FVC values, whereas on average cigarette smoking does not produce a loss in FVC. *Id.* at 73-74. He concluded that both tobacco smoke and coal dust exposure contributed to Claimant's impairment. *Id.* at 84. Dr. Cohen determined that Claimant has a nonreversible obstructive impairment, and that he could only perform light activity. *Id.* at 79. Based on all of the evidence, Dr. Cohen opined that Claimant could not perform his last job. *Id.* at 97. Dr. Cohen testified that Claimant's heart condition was not a factor in Claimant's disability because his left ventricular function was preserved and he did not have any significant myocardial damage on the cardiac catherization. *Id.* at 100-101.

Dr. Fino prepared a supplemental medical report dated November 14, 2002. (EX 12). Dr. Fino summarized the additional medical evidence that he reviewed, and concluded that it did not change his previously stated opinions.

Dr. Renn prepared a supplemental medical report dated December 6, 2002. (EX 15). Dr. Renn discussed his previous examination of Claimant. He stated that Claimant was not using oxygen during the examination because he did not note its use in his handwritten notes and there was no evidence of the oxygen tubing on the chest x-ray films.

Dr. Fino was deposed on June 25, 2003. (EX 21). Dr. Fino stated that Claimant's emphysema is due to tobacco smoking because emphysema due to coal dust exposure is directly proportional to the amount of coal dust in the lungs, which is directly proportional to the ILO classification of a chest x-ray, and since Claimant's chest x-rays were classified as 0/0, then his emphysema could not be due to coal dust exposure. *Id.* at 16. He stated that if Claimant had emphysema due to coal dust exposure, then it would have been evident on the 1986 pulmonary function study. *Id.* at 36. Dr. Fino also stated that Claimant's hypoxia deteriorated over time, which is also consistent with a cigarette smoking induced emphysema. *Id.* at 23-24. Dr. Fino opined that Claimant's cough, sputum production, and occasional wheezing are due to his obstructive lung disease. *Id.* at 11. After reviewing the pulmonary function studies, Dr. Fino concluded that Claimant has an obstructive abnormality that has worsened since he left coal mine employment, but that the significant cause of his impairment is tobacco smoking. *Id.* at 15. He determined that coal dust is not a significant cause of Claimant's impairment because Claimant had a one liter drop in his FEV1 values between 1986 and 2001, and that a lung disease that is smoking related progresses at a higher rate per year than a coal dust related lung disease. *Id.* at 18, 20. Dr. Fino testified that, contrary to Dr. Cohen's report, he did not just apply the epidemiological studies to Claimant, but rather he looked at all of the factors to determine the cause of Claimant's impairment. *Id.* at 54-55. Dr. Fino testified that, based on the pulmonary function study results, he would not diagnose asthma. *Id.* at 26. He stated that Claimant's type of cardiac disease would not contribute to a reduction in FEV1 or diffusing capacity values. *Id.* at 27-28. Dr. Fino opined that Claimant could not perform his last job because it involved a lot of walking, stooping, and crawling, which he could not longer carry out based on his FEV1 and oxygen levels. *Id.* at 9, 24. However, Dr. Fino concluded that Claimant's disability is due to cigarette smoking. *Id.* at 24.

Treatment Records

The record includes treatment notes from Dr. Devender K. Batra dated February 7, 1997 to October 23, 2000 and Dr. George P. Naum on February 18, 1993. (DX 16). These records deal with Claimant's treatment for coronary artery bypass graft and hypertension. A diagnostic report dated February 1, 1993 noted that Claimant had a twenty-five pack year history of smoking cigarettes. The record also includes an operative report dated February 10, 1997, when Claimant underwent a triple coronary artery bypass. (DX 17).

The treatment notes from Dr. Lenkey dated September 16, 1998 to January 30, 2002, are included in the record. (CX 5). The notes indicate that Dr. Lenkey was treating Claimant for chronic obstructive pulmonary disease and emphysema. On March 5, 2001, May 10, 2000, and June 7, 2000, Dr. Lenkey noted diminished breath sounds.

The record includes treatment records from Dr. Batra dated February 25, 2002 to April 16, 2003. (EX 20). Dr. Batra was treating Claimant's heart disease. After each examination,

Dr. Batra determined that Claimant was status-post aortocoronary bypass and that his hypertension was controlled by the medication.

Conclusions of Law

Length of Coal Mine Employment

Employer stipulated to nineteen years of coal mine employment, but Claimant argues that he worked in the coal mines for thirty-one years. (TR 61). Claimant testified that he worked in the coal mines from 1954 to 1985. (TR 61, 64). Claimant testified that he worked for Liberty Coal Company from 1954 to 1967, and then he worked for Valley Camp Coal Company[8] from 1967 to 1985. (TR 61-64). The record includes a letter from Liberty Coal Company stating that Claimant was its employee from February 9, 1954 to January 1, 1967. (DX 5). The record also includes a letter from Valley Camp Coal Company indicating that Claimant was its employee from January 3, 1967 to September 1, 1985. (DX 5). I find that Claimant has thirty-one years of coal mine employment based on Claimant's credible testimony and the documentary evidence in the record.

Material Change in Conditions

This claim was filed after January 19, 2001, and is governed by the amended regulations. As the present claim is the miner's second claim for benefits, and it was filed more than one year after the denial of the miner's prior claim, the evidence must "demonstrate that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final," or else the claim will be denied. § 725.309(d); *see also Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd*, 86 F.3d 1358 (4th Cir. 1996)(en banc), *cert. denied*, 117 S.Ct. 763 (1997). None of the elements of entitlement were found to be established in the miner's previous claim, which was denied by the district director on January 26, 1987.

Benefits are provided to miners who are totally disabled due to pneumoconiosis. § 718.204(a). Claimant has the burden of proving by a preponderance of the evidence that he has pneumoconiosis arising out of coal mine employment and that he is totally disabled as a result. *Gee v. W.G. Moore & Sons, Inc.*, 9 B.L.R. 1-4 (1986). A finding of the existence of pneumoconiosis may be based on chest x-rays, autopsies or biopsies, the presumptions in §§ 718.304, 718.305, or 718.306, or the reasoned medical opinion of a physician that the miner has pneumoconiosis as defined in § 718.201.[9] § 718.202(a)(1)-(4). All types of relevant evidence must be weighed to determine if the miner has pneumoconiosis. *Island Coal Creek Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

[8] Valley Camp Coal Company reorganized into Elm Grove Coal Company in 1983. (DX 1-14).

[9] Pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment, and it includes both medical, or clinical, pneumoconiosis and statutory, or legal, pneumoconiosis. § 718.201(a).

The record includes eleven interpretations of four chest x-rays; of the eleven interpretations, six are positive for pneumoconiosis, four are negative for pneumoconiosis, and one interpretation only addresses the quality of the x-ray film. In evaluating the chest x-ray interpretations, the qualifications of the physicians reading the x-rays must be taken into account. § 718.202(a)(1). The x-ray interpretations of physicians who are board-certified radiologists and B-readers are entitled to the greatest weight. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). Drs. Ahmed, Noble, and Miller, who are dually-qualified physicians, found radiographic evidence of pneumoconiosis. Dr. Wiot, also a dually-qualified physician, found no radiographic evidence of pneumoconiosis. I find that a preponderance of the x-ray evidence establishes the existence of pneumoconiosis.

There is no biopsy evidence and the enumerated presumptions are not applicable to this claim.

The record includes the medical opinions of five physicians. Drs. Cohen, Lenkey, and Reddy diagnosed coal workers' pneumoconiosis and Drs. Reddy and Lenkey diagnosed chronic obstructive pulmonary disease due to coal dust exposure and tobacco smoking. Dr. Fino diagnosed chronic bronchitis and emphysema secondary to tobacco smoking. Dr. Renn diagnosed emphysema and asthma due to tobacco smoking. All of the physicians are board-certified pulmonologists and thus are equally qualified to render opinions as to the nature and extent of Claimant's impairment.

It is well-settled that pneumoconiosis has both a medical and legal definition. § 718.201(a); *see also Clinchfield Coal Co. v. Fuller*, 180 F.3d 622, 625 (4th Cir. 1999); *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821 (4th Cir. 1995). Medical pneumoconiosis is a lung disease diagnosed by x-ray opacities indicating nodular lesions on the lungs. *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976); *see also* § 718.201(a)(1). Legal pneumoconiosis is a broader category of diseases, and includes "any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." § 718.201(a)(2); *see also Hobbs*, 45 F.3d at 821. Section 718.201(b) defines "arising out of coal mine employment" as any chronic respiratory or pulmonary impairment "significantly related to, or substantially aggravated by, [coal] dust exposure." Evidence that does not establish medical pneumoconiosis, i.e., an x-ray read as negative for pneumoconiosis, is not evidence against establishing legal pneumoconiosis. *Hobbs*, 45 F.3d at 821.

Dr. Cohen opined that Claimant has coal workers' pneumoconiosis based on his symptoms, physical examinations, pulmonary function studies, arterial blood gas studies, and history of coal dust exposure. Dr. Cohen attributed Claimant's chronic lung disease to his coal dust exposure and tobacco smoking. He stated that based on his review of the literature, if an individual was exposed to both tobacco smoking and coal dust, then those exposures would have an "additive effect" and both would contribute to the individual's impairment. (EX 4, pp. 16-17). Dr. Cohen did not examine Claimant, but he did have an opportunity to review all of the medical evidence in the record. A non-examining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984); *Easthom v. Consolidation Coal Co.*, 7 B.L.R. 1-397 (1987). I find that the evidence as a whole corroborates

Dr. Cohen's opinion. I also find that his opinion is supported by the objective medical evidence.[10] *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90, n.1 (1986). Dr. Cohen explained what medical evidence his diagnosis of pneumoconiosis is based and why he concluded that Claimant's chronic lung disease is due to both tobacco smoking and coal dust exposure. I find that Dr. Cohen's opinion is well-documented and well-reasoned. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Further, I find that Dr. Cohen possesses impressive credentials related to diagnosing occupational lung diseases. For these reasons, I find that Dr. Cohen's opinion is entitled to great weight.

Dr. Lenkey diagnosed coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Lenkey diagnosed coal workers' pneumoconiosis based on the positive interpretations of the chest x-rays. As a preponderance of the chest x-ray evidence is positive for pneumoconiosis, I find that the x-ray evidence of record supports Dr. Lenkey's diagnosis of coal workers' pneumoconiosis. Dr. Lenkey also diagnosed chronic obstructive pulmonary disease based on Claimant's symptoms, physical examinations, chest x-rays, and pulmonary function studies. Dr. Lenkey stated that Claimant's coal dust exposure and tobacco smoking had an additive effect, and he would attribute fifty percent of Claimant's impairment to coal dust exposure and fifty percent to tobacco smoking. As stated above, legal pneumoconiosis includes chronic obstructive pulmonary disease if it arose out of coal mine employment. Dr. Lenkey stated that Claimant's coal dust exposure and tobacco smoking had an additive effect, indicating that Claimant's impairment would not be as severe had he only been exposed to coal dust or tobacco smoking. I find that Dr. Lenkey's opinion establishes that Claimant's chronic obstructive pulmonary disease is significantly related to his coal dust exposure, and thus it establishes the existence of legal pneumoconiosis. Further, I find that Dr. Lenkey's opinion is well-documented and well-reasoned, and supported by the objective medical evidence. For these reasons, I accord great weight to Dr. Lenkey's opinion.[11]

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[10] I find that Dr. Cohen's opinion is not undermined by his use of the Intermountain Thoracic Society (ITS) predicted normals in evaluating the pulmonary function study evidence. While the ITS predicteds are based on a small population, I find that their use by Cook County Hospital and Dr. Fino indicates that they are acceptable predicteds for evaluating the results of pulmonary function testing. (EX 4, p. 37, 21, pp. 50-51).

[11] Section 718.104(d) states that when weighing the medical evidence, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall consider the nature and duration of the physician-patient relationship and the frequency and extent of treatment when weighing the opinion of the treating physician. *Id.* Here, Dr. Lenkey treated Claimant for approximately four years. Dr. Lenkey, a pulmonologist, was treating Claimant's obstructive lung disease, and thus has a good understanding of Claimant's symptoms and condition. He also reviewed all of the medical evidence of record, and thus was familiar with the medical testing performed at other facilities. However, Drs. Cohen, Fino, and Renn also reviewed the medical evidence of record, and thus these physicians' understanding of Claimant's condition was comparable to Dr. Lenkey's. I find that Dr. Lenkey is not entitled to controlling weight merely because of his status as Claimant's treating physician. Nevertheless, for the reasons stated above, I accord great weight to Dr. Lenkey's opinion.

Dr. Reddy diagnosed coal workers' pneumoconiosis based on Claimant's history of coal dust exposure and a positive chest x-ray interpretation. He also diagnosed chronic obstructive pulmonary disease based on Claimant's history of coal dust exposure and the results of the physical examination, pulmonary function study, and arterial blood gas test. Dr. Reddy found that tobacco smoking and coal dust exposure contributed to Claimant's chronic obstructive pulmonary disease. First, I find that the x-ray evidence of record supports Dr. Reddy's diagnosis of coal workers' pneumoconiosis, as a preponderance of the chest x-ray evidence is positive for pneumoconiosis. Second, I find that Dr. Reddy's diagnosis of chronic obstructive pulmonary disease is supported by the objective medical evidence and that his opinion is well-reasoned. Further, I find that Dr. Reddy's opinion is buttressed by Drs. Cohen and Lenkey's findings that both coal dust exposure and tobacco smoking contributed to Claimant's chronic lung disease. For these reasons, I find that Dr. Reddy's opinion is sufficient to support a finding of legal pneumoconiosis and I accord his opinion great weight.

Dr. Fino diagnosed chronic bronchitis and emphysema and attributed the diseases solely to tobacco smoking. Dr. Fino ruled out coal dust exposure as a cause of Claimant's chronic bronchitis and emphysema because the chest x-rays were negative for pneumoconiosis and the pulmonary function study and diffusing capacity results were consistent with cigarette smoking. First, the chest x-ray evidence that Dr. Fino reviewed is not representative of the x-ray evidence in the record. Dr. Fino reviewed nine x-ray interpretations that are not in the record and failed to review five x-ray interpretations that are in the record. As a preponderance of the chest x-ray evidence is positive for pneumoconiosis, I find Dr. Fino's opinion that there is no radiographic evidence of pneumoconiosis to be inconsistent with the x-ray evidence in the record. Similarly, I find that Dr. Fino's opinion that Claimant does not have coal workers' pneumoconiosis or emphysema based on the negative x-ray evidence is inconsistent with the x-ray evidence of record. Further, Dr. Fino stated in his medical reports and during the deposition that Claimant's obstructive lung disease is due solely to cigarette smoking because the results of his pulmonary function testing progressed after he left the mines. Dr. Fino acknowledged that coal workers' pneumoconiosis can be progressive (EX 21, p. 6), but he determined that Claimant's impairment was not related to coal dust exposure because his FEV1 was normal when he left the mines, then subsequently declined. I find that Dr. Fino only considers clinical pneumoconiosis to be progressive, which is contrary to § 718.201(c). For these reasons, I find that Dr. Fino's opinion is not reasoned and thus accord less weight to the medical opinion of Dr. Fino.

Dr. Renn found that Claimant does not have pneumoconiosis, but rather diagnosed emphysema and asthma due to tobacco smoking. Dr. Renn ruled out coal dust exposure as a cause of Claimant's emphysema because his emphysema was radiographically appreciable. He explained that Claimant's impairment is not due to legal pneumoconiosis because he had a reduction in the indirect measures of the small airways, bronchoreversibility, reduced lung volumes, and no restrictive impairment. First, Dr. Renn's opinion that Claimant's impairment must include a restrictive component in order to be legal pneumoconiosis is contrary to the regulatory definition of legal pneumoconiosis. *See* § 718.201(a)(2)(Legal pneumoconiosis… "includes any chronic restrictive *or* obstructive pulmonary disease…"). Second, Dr. Renn stated

that Claimant had significant FVC reversibility after the administration of bronchodilators, which is not consistent with a coal dust induced lung disease. However, Dr. Renn does not discuss the significance of Claimant having a normal FVC value pre-bronchodilator, which seems to minimize the importance of the reversibility. Third, Dr. Renn diagnosed asthma in part based on Claimant's complaint of wheezing, even though Dr. Renn reported occasional wheezing and Dr. Reddy reported wheezing rarely. Moreover, Claimant testified that he has never been diagnosed with asthma and Drs. Cohen and Fino stated that they would not diagnose asthma. I find that the medical evidence does not support a diagnosis of asthma. For these reasons, I find that Dr. Renn's opinion is not reasoned and accord it little weight.

Based on all of the physician opinion evidence, I find that Claimant has established that he has pneumoconiosis. As stated above, I am required under *Compton* to weigh all of the evidence together to determine if Claimant has established the existence of pneumoconiosis. 211 F.3d at 211. I previously found that the chest x-ray and physician opinion evidence established pneumoconiosis. After weighing all of the evidence together, I find that Claimant has established the existence of pneumoconiosis. Claimant has established an element of entitlement that was previously adjudicated against him. All of the evidence must now be evaluated to determine if Claimant is entitled to benefits.

The prior claim contains two negative interpretations of the September 18, 1986 x-ray. As stated previously, the current claim contains six interpretations that are positive for pneumoconiosis and four interpretations that are negative for pneumoconiosis. The most recent chest x-rays can be given more weight under the concept "later evidence is better" as pneumoconiosis is a progressive disease. *See Adkins v. Director,* OWCP, 958 F.2d 49 (4th Cir. 1992); *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). Here, there is a fifteen year span of time between the x-ray evidence in the prior claim and in this claim. I find that this span of time is significant, and that the current x-ray evidence should be given more weight. In the current claim, three dually-qualified physicians found radiographic evidence of pneumoconiosis, whereas one dually-qualified physician found no radiographic evidence of pneumoconiosis. I find that a preponderance of the most recent chest x-ray evidence establishes that Claimant has coal workers' pneumoconiosis.

The prior claim contains the medical report of Dr. Burke. Dr. Burke found that there was no evidence of cardiopulmonary disease. Subsequently, Claimant had a triple coronary bypass, and Drs. Cohen, Fino, Lenkey, Reddy, and Renn diagnosed Claimant with an obstructive lung disease. As pneumoconiosis is a progressive disease and Claimant's condition has deteriorated since 1986, I accord more weight to the recent findings of pneumoconiosis than to Dr. Burke's finding of no cardiopulmonary disease.

Claimant is entitled to the presumption in § 718.203(b) that his pneumoconiosis arose out of coal mine employment because of his thirty-one years of coal mine employment. This presumption has not been rebutted.

A miner shall be considered totally disabled if the irrebuttable presumption in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if his

pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. § 718.204(b)(2).

The record contains six pulmonary function studies. Two of the pulmonary function studies produced qualifying values. I find that the pulmonary function study evidence does not establish that Claimant is totally disabled.

The record contains four arterial blood gas tests. The two most recent arterial blood gas tests, dated June 20, 2001 and September 27, 2001, produced qualifying values. As stated before, more weight can be given to the most recent evidence under the "later is better" rule. I find that the arterial blood gas tests performed in 2001 are more representative of Claimant's current ability to oxygenate blood than the 1986 and 1993 studies. Therefore, I find that the most recent blood gas tests establish that Claimant is totally disabled.

There is no evidence that Claimant has cor pulmonale.

There are five physician opinions that address whether Claimant is totally disabled.[12] Drs. Cohen, Fino, Lenkey, and Reddy found that Claimant is totally disabled and cannot perform his last coal mine job. Dr. Renn found that Claimant is not totally disabled. Drs. Cohen, Fino, Lenkey, and Reddy's opinions that Claimant is totally disabled are based on the results of the pulmonary function and arterial blood gas studies. I find that the objective medical evidence supports their conclusions that Claimant is totally disabled. In contrast, I find that Dr. Renn's opinion that Claimant is not totally disabled is not well-documented or well-reasoned. Dr. Renn testified that he concluded that Claimant was not totally disabled because a 1986 article entitled "The Evaluation of Impairment/Disability Secondary to Respiratory Disorders," which stated that "an FEV1 that is in the range of 60 to 79 percent of predicted qualified him for their rating of impairment as mildly impaired. And they put in parentheses the statement, "(usually not correlated with diminished ability to perform most jobs)." (EX 1, pp. 35-36). However, Dr. Renn did not know what types of jobs were included in the category of "most jobs." *Id.* at 74-75. Further, Dr. Renn based his opinion on the results of a 1997 exercise stress test in relation to a pilot study of the exertional requirements of coal miners. *Id.* at 37. This study did not include Claimant's job, but only included a "fireboss and section foreman." *Id.* Further, this study only included twelve miners. (EX 4, p. 106). Dr. Renn does not explain how this research is representative of Claimant's last job and its exertional requirements, but rather asserts that Claimant can perform his last job based on this research. I find that Dr. Renn did not actually consider the exertional requirements of Claimant's last job and the objective testing results, but rather relied on this research to find that Claimant can perform his last job. Because Dr. Renn

[12] Dr. Burke's opinion only addresses whether Claimant has a cardiopulmonary disease, and thus is not probative on this issue.

did not explain how this research supports his conclusions, I find that Dr. Renn's opinion is not reasoned and thus accord it little weight.

After weighing all of the evidence, I find that Claimant is totally disabled. A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's total disability if it has a material adverse effect on his respiratory or pulmonary impairment or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. § 718.204(c)(1).

Drs. Cohen, Lenkey, and Reddy attributed Claimant's total disability to his pneumoconiosis. Dr. Fino attributed Claimant's total disability to his tobacco induced lung disease.[13] Dr. Fino did not diagnose Claimant with clinical or legal pneumoconiosis, which is contrary to my finding that the medical evidence in the record does establish the presence of clinical and legal pneumoconiosis. In *Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002) and *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109 (4th Cir. 1995), the Fourth Circuit stated that when an administrative law judge (ALJ) finds the existence of pneumoconiosis and total disability, a physician's opinion to the contrary can only be credited if the ALJ "identif[ies] specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon [his] disagreement with the ALJ's finding as to either or both of the predicates in the causal chain," *Id.* at 116, and even then it "can carry little weight, at the most." 289 F.3d at 269. Here, I cannot identify a specific and persuasive reason to credit Dr. Fino's opinion, and therefore I find that his opinion is entitled to little weight. Drs. Cohen, Lenkey, and Reddy attributed Claimant's total disability to his obstructive lung disease arising, in part, out of coal mine employment. For the reasons stated above, I find that their opinions are supported by medical evidence of record and are reasoned. Thus, I accord great weight to the opinions of Drs. Cohen, Lenkey, and Reddy.

After reviewing all of the evidence on the issue of causation, I find that a preponderance of the physician opinion evidence establishes that pneumoconiosis is a substantially contributing cause of Claimant's total disability.

The evidence establishes all the elements of entitlement. Benefits will be awarded as of April 1, 2001, the first day of the month in which the claim was filed. § 725.503(b). Claimant's counsel has thirty days to file a fully supported fee application and his attention is directed to §§ 725.365 and 725.366. Employer's counsel has twenty days to respond with objections.

[13] Dr. Renn did not find that Claimant is totally disabled, and thus his opinion is not probative on this issue.

ORDER

IT IS ORDERED THAT Elm Grove Coal Company:

1. Pay Claimant all the benefits to which he is entitled, augmented by one dependent, beginning as of April 1, 2001;

2. Pay Claimant all the medical benefits to which he is entitled beginning as of April 1, 2001;

3. Reimburse the Black Lung Disability Trust Fund for interim payments made to Claimant; and

4. Pay interest to the Black Lung Disability Trust Fund on unpaid benefits at the rates set forth in § 725.608.

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DANIEL L. LELAND
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601***. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.